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The HOSPITAL MEDICAL and NURSING WORLD

CONTINUING THE HOSPITAL WORLD

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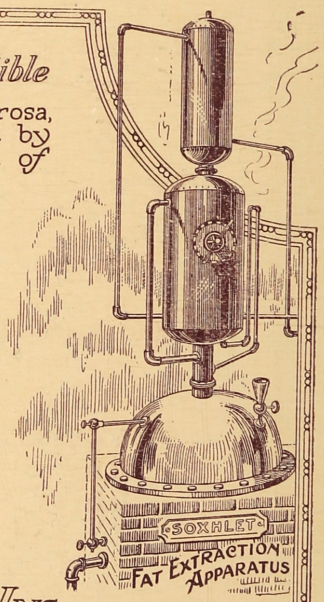
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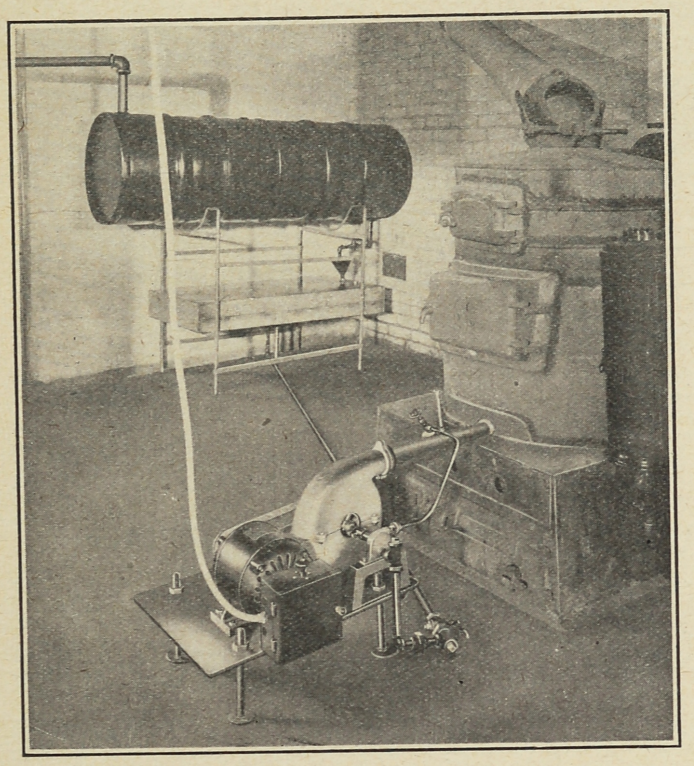


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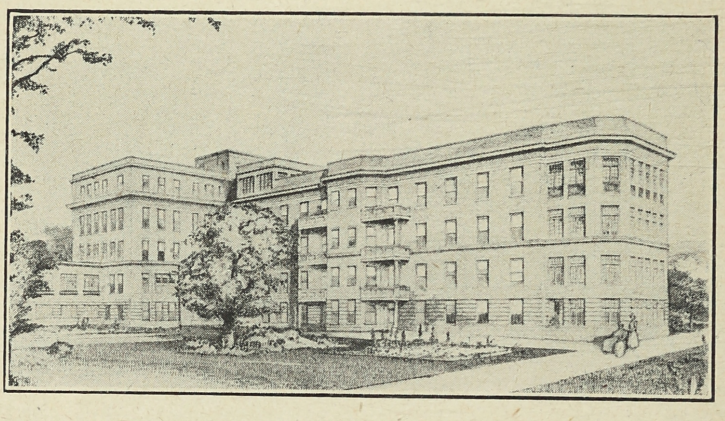
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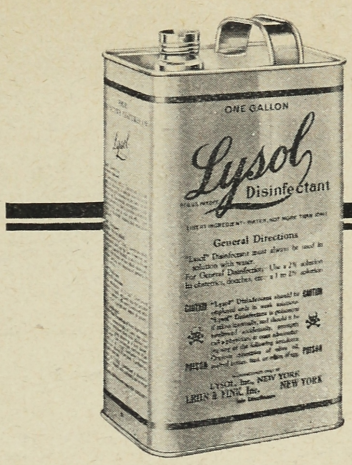
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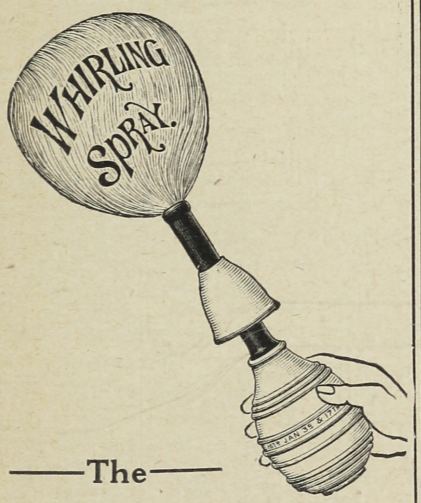
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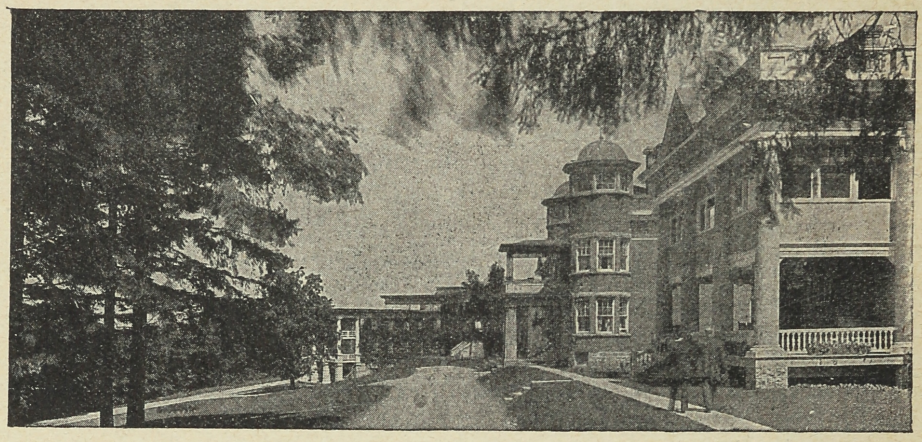
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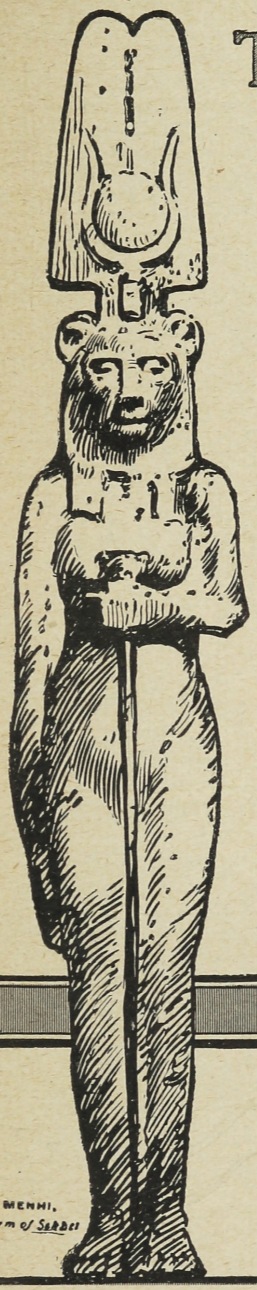
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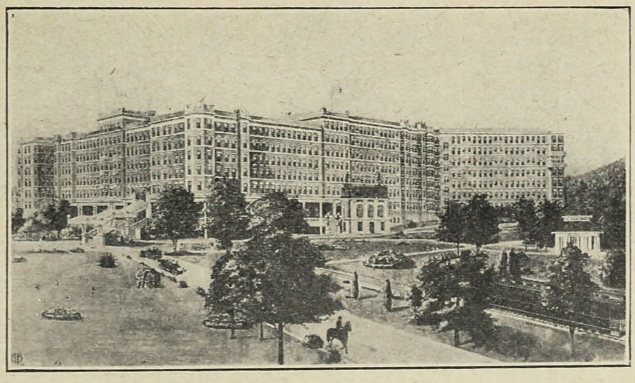
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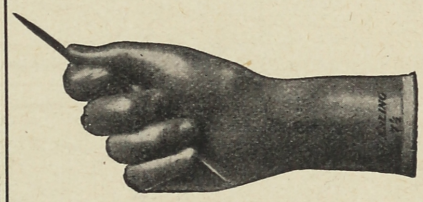
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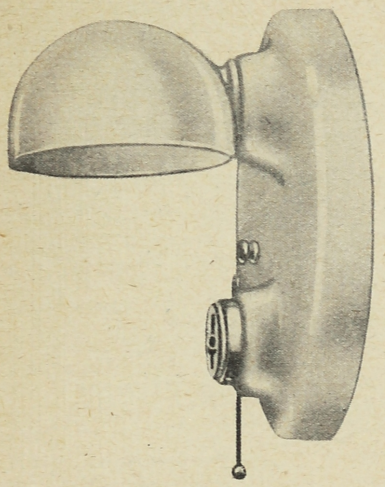
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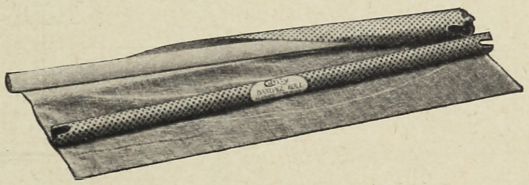
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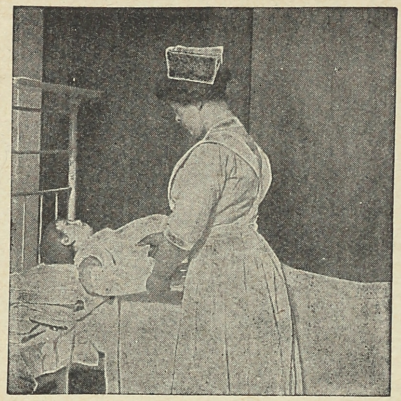


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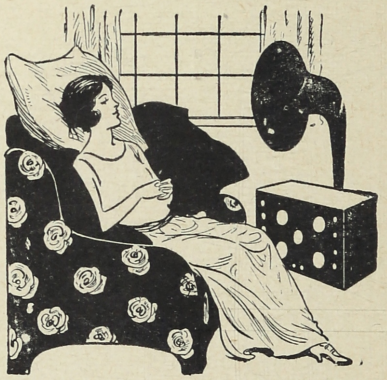
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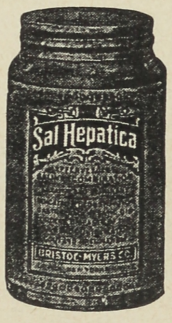
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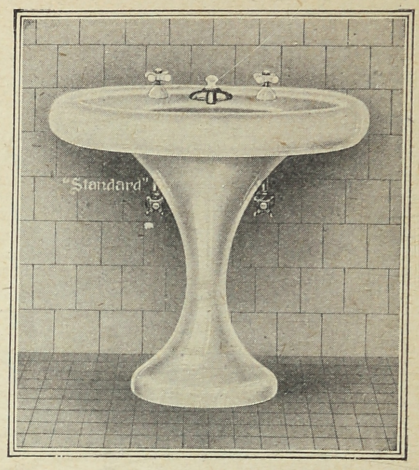


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THE HOSPITAL, MEDICAL AND NURSING WORLD

TORONTO, CANADA

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Editorial

Hospital Construction

The committee of the American Hospital Association on this subject recommends that all service connections should be carried in either the outer or inner wall of the building, leaving the partitions free, and that all partitions should be built on top of the finished concrete floor in order that if they are moved the floor need not be patched. This makes it possible to shift partitions at minimum expense. In a western hospital the only fixed portion of the ward floors is the service room unit. This permits of inexpensive alterations or enlargements in future.

One member of the committee advocates the use of numerous daylight lamps, inasmuch as they blend perfectly with daylight and can be used satisfactorily in this manner or completely excluding daylight. Another member recommends an individual refrigerating unit on each floor of the private patients building, using sulphur dioxide.

There is a new sound-absorbing material on the market—"pure bagasse fibre" (non-capillary).

It comes in slabs one inch thick and is applied to the ceiling with joints tightly abutted or tuck-pointed.

Where finances are short for building construction, the ward capacity should be cut down rather than the central service department, seeing the wards can be more readily added to than the service.

The committee draws attention to the so-called "hotel hospital"—a building to be used as part hotel and part hospital—as at Rochester, Minn. It is a building of many storeys, the lower ones being equipped with hotel features, while essential hospital equipment is concentrated in the upper storeys. The intermediate floor rooms with baths and toilets may be rented either to ordinary hotel guests or to patients.

The committee called attention to the dangers which lurk in the extreme application of the principle, so much in vogue of late, of concentration in planning so as to economize in building material and to facilitate medical, nursing, and administrative work. Hospital buildings should not be planned for compactness alone, but also with regard to the demands for sunlight, flexibility of design, natural ventilation and facilities for outdoor treatment.

The committee endorses the Federal bureau—a centre for advice on construction, equipment, etc.

The committee stressed the underlying principles of hospital planning: unity, diversity, facility of operation, flexibility, health and economy.

UNITY.

A well-ordered hospital which is doing advanced and thorough work necessarily contains many clinical and

other subdivisions. The specialized character of these subdivisions readily suggests the splitting of the hospital into many parts. Swayed by departmental interests, the architect is apt to be led away from the fundamental idea that the hospital is an organic unit which cannot function vigorously unless all of its departments function in harmony. The tendency of individual departments to detach themselves from the group should be combated in planning a general hospital, and the unity of the hospital preserved.

Diversity.

Certain principles of orientation, size, and arrangement are valid, respectively, for a particular department of a hospital, and these principles must be respected. If the architect considers separately each distinctive function and plans for it appropriately, a variety of structural outlines will emerge. If he then proceeds to build for each function, regardless of its place and relations in the general scheme, chaos will result. While the value of diverse forms must be recognized, the necessity of combining these forms into a practicable unit must not be overlooked. On the other hand, if a plan is adopted which is simple and which is selected on account of its correspondence to some particular hospital function, the resulting building may be satisfactory in part, but will not give satisfaction as a whole.

Facility of Operation.

The degree of ease with which a hospital can be operated depends on the location of the site, the disposition of entrances and exits, the grouping in space of interdependent departments, and the arrangement or placing of working equipment. The accessibility of the hospital to its clientele is important, and in this connection patients, visitors to patients, the medical staff, and the nursing staff must be separately considered. Entrances and exits must be conveniently arranged for the groups just named, as well as for domestic employees, for goods, for waste and for the dead. Internal circulation, or transport and service lines, demand the closest study. For example, the wide separation of (a) the supply entrance from the kitchen, (b) the visitors' entrance from the elevators, (c) the visitors' elevators from the nurses' control stations,

(d) the operating rooms from the surgical wards, (e) the out-patients' department from the admitting ward or from the radiographic department, (f) the ward utility room or the linen room from the centre of the group of beds to which it is annexed, interferes with facility of operation. These examples will perhaps suffice to show that an intimate knowledge of hospital service is indispensable in planning, and that the difficulty of applying such knowledge is especially great in the case of large and complex general hospitals, in which service lines cross each other many times.

Flexibility.

Experience has shown that the conditions which constitute the environment of the hospital are constantly undergoing modifications; social changes, community growth, and scientific discovery, create new demands which the hospital is called upon to satisfy. Healthy hospitals are growing hospitals, but their growth is not necessarily symmetrical. New discoveries are constantly opening up new lines of medical treatment which call for new space-consuming therapeutic apparatus. Nursing standards are forever advancing. Novel forms of record keeping are devised, and presently are regarded as indispensable. A hospital which begins as a medical boarding house is eventually called to participate in health education, in the clinical training of medical students, in post-graduate medical teaching, in scientific research. A sudden windfall enables the hospital to add a new or larger maternity department, an orthopedic department, a "tonsil clinic," a children's health centre. Pressure is constant, both from within and without, and the hospital must be in a position to accommodate itself to every reasonable demand. An inflexible plan is a forerunner of trouble.

Health Values.

A hospital which is not rich in health values is a failure. Health values do not reside exclusively in smooth walls, smooth floors and rounded inner corners; they are many and varied, including certain values which tend directly to the promotion of health, such as the proper orientation of wards, the sun exposure of balconies, grounds or flat roofs accessible to patients, effective venti-

lation, quiet bedrooms for night nurses, advantageously placed dormitories and recreation rooms for the resident staff, proper sleeping quarters for other resident employees, a cheerful and tonic outlook; and also features which tend to the prevention of disease or the mitigation of suffering, such as receiving wards, quiet rooms, isolation wards, sterilizing equipment of many kinds, sanitary construction, devices for noise prevention, restful colorings, etc.

Economy.

Economy in hospital construction includes economy in production and economy in use. It is a mistake to consider building cost apart from maintenance cost. Broadly speaking, economy in use is more important than economy in production. A metal door frame may be cheaper in the end than a frame of wood, a tile or terrazzo floor may be cheaper in the end than one of composition, a white metal faucet may be cheaper than a red, a copper cornice cheaper than one of galvanized iron. Durability is not extravagance. Extravagance in hospital construction resides in mere exterior decoration; in the use for interior finish of costly materials which are not especially durable or easy to care for; in waste of space; such extravagance carries with it the penalty of high maintenance costs.

Generally speaking, a concentrated institution is cheapest to build and to operate, but extreme concentration and simplicity of design which disregard the diverse demands of varied functions ultimately defeat their own ends; when concentration and simplicity are carried too far, the hospital is forced either to live in a straight-jacket or to cast off its original garment and acquire a new and more appropriate one.

To spend without the assurance of proportionate present or future gain is to be extravagant. An economical hospital is one in which every cubic foot of construction gives the maximum service attainable, under the given conditions.

The Outside of the Building

A writer in one of our contemporaries draws attention to the psychological effect of the appearance of the hospital building on the public, maintaining that all efforts required for its maintenance are repaid. Mr. Wylley holds that the whole four fronts need attention. Where a hospital building comes up to the side of the street he advises hospital authorities to even clean the strip between the curb of the walk and the centre line of the street—sweep and sprinkle. Early in the morning he would commence cleaning the base of the building where it joins the sidewalk, using soap and soda solution applied by a scrubber or old stiff broom. Then the sidewalk, then the street.

Plate glass windows are washed with clean cold water in which four tablespoonfuls of ammonia are dissolved, applied with a round window brush and followed by a rubber squegee, the rubber being wiped with chamois after each downward stroke. Then the chamois is folded over the rubber and the window is finished. Never use soap on plate glass.

Then comes the bright work and traffic signs; which must be washed and polished. Then the lights of the building front taken care of, and right now is a good time to remind you that it is a good practice to try out your night lights, just before you go off duty every day.

Cleaning in the Rear.

In the rear of the building the same systematic arrangement of work is followed, except that if you have refuse or other matter to be removed, try to arrange for its removal very early in the morning,

so that it will not interfere with your work or the traffic. The removal of refuse is a daily task and it must not be permitted to accumulate. During the day it should be kept in covered containers and if possible, out of sight.

The work outlined here is that which requires daily attention. There are things which need constant care—the roof is one of these. The flat roof seems to hold first place in popularity. This roof is generally finished with a tar or pitch preparation, upon which course gravel is spread out evenly. Such a roof is not intended to bear traffic, and while it is an ideal place during the summer upon which to take lunch, it should not be used for such a purpose unless a special flooring has been provided. Patching is done by removing the gravel and applying tar that has been heated, so that it will pour readily.

Waterways (if of metal), metal coverings on roof housings and steel stay wires or cables on chimney and flag poles must be given a yearly coat of red lead and then painted in order to protect them from deterioration. Fire escapes must be carefully inspected and painted if necessary. If the fire escape is a self-lowering one, the cable will need yearly attention.

Dirty Skylights Cut Efficiency.

Glass skylights are provided in order to supply light. If they are dirty, 50 per cent. of their efficiency is lost; that means they must be gone over about once each week in order to keep them just right.

Light wells or courts are always in need of attention and should be swept and washed off once a week.

If you have an incinerator on the outside of the building it must be kept clean and free from objectionable odors. This can be accomplished by the liberal use of hot water, chloride of lime and pine disinfection. The disinfection should always be sprayed, not just emptied into the room. Washing out with hot water is probably the most effective way to keep the incinerator building in good shape. This is the place from which your summer supply of flies will come out if you permit them to breed there, and they will surely find places to breed if you do not use every possible precaution to assure perfect cleanliness.

Paths and roads about the buildings and grounds need attention and should be given an occasional sprinkling. Provision should be made in one or more convenient places along the road to supply water to automobiles of patrons for this purpose. For this purpose a hose is provided, and the vicinity kept free from papers and refuse.

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Original Contribution

THE HOSPITAL—ITS PROBLEMS

C. J. Decker, Superintendent, Toronto General Hospital

Since we are to consider the hospital it would seem fitting to define a hospital.

You have doubtless heard many definitions of a hospital which I am sure would describe it more elaborately and completely than the definition I have in mind for the purpose of this discussion. Webster defines it as "an institution or place in which sick or injured are given medical or surgical care." Correct, as far as it goes, but extremely mechanical and omitting the vital factor—interest. I have, however, chosen to define a hospital as a group of citizens who, prompted by altruistic motives, join together in an endeavor to meet certain community needs.

A hospital is neither a geographical location, a pile of bricks and mortar, or even an administrative machine. It is essentially a group of human beings organized to perform a human service. A steel company, for example, exists first in the brain of an individual and then in a group of directors, perhaps long before a single blast furnace is erected. So a hospital lives, first in the imagination of some individual, then in the hearts of a group of men and women: the first board of trustees, and finally is incorporated in buildings, staff and organization. The essential elements in a hospital are all human, and the chief difficulties which have to be faced by a board of trustees are those which arise out of human factors. The success or failure of any great enterprise is largely dependent upon the manner in which the directors face the innumerable problems confronting them. So it is with the hospital: its success, in the final analysis, depends upon how the trustee board meets its various problems.

Having joined together and organized to meet certain community needs, let us consider what these needs are. To be

sure, we will require suitable building or buildings designed and fully equipped with every facility for caring for and treating the sick and injured of the community. The matter of providing suitable accommodation for the several classes seems to involve only difficulties of a physical and financial nature. Yet anyone who has ever been responsible for the choice of a hospital plan and the concrete carrying out of the plan finally settled upon, knows that the chief difficulties are those involved in human psychology.

The buildings and equipment are an indispensable prerequisition of operation, but both before and after these are provided, the difficulty of adapting them to the needs of the various sections of society faces the board of trustees.

It is easy to provide families with over $10,000 income with suitable hospital service. It is also easy to provide families with $1,000 income, but what about the family with $2,000, $3,000 or $4,000 income, which can neither accept charity nor pay for private service? Thus we have before us the problem of providing suitable accommodation for the several classes of the community.

Again the hospital may be in a university centre. Immediately confronting the trustee board is a demand from the university element for teaching facilities within the hospital, and cognizant of the importance of clinical instruction in the teaching of medicine and surgery to students, the board of trustees accept this as one of their obligations to the community. University interests may demand a closed hospital, or they may demand only a partially closed hospital. In either event there is inevitable friction, hard feeling on the part of the medical men not on the staff, criticism from some patients who find that their own physicians cannot follow them into the hospital, and, more or less, wide charges that the interests of the hospital have been sacrificed to the university. If we are to expect our university to be successful in medical education we must give it comparative freedom in rounding out its medical educational programme as it involves the hospital.

Again the matter of appointments to the hospital staff is one which does not make the trustees' burden the lighter.

These are a few of the problems of general policy which face the board of trustees of a hospital. The hospital with which I am best acquainted is the Toronto General Hospital. It may interest you to know of how its board has tried to solve some of its major problems. I do not attempt to suggest that

the methods worked out in connection with the Toronto General Hospital are the best possible, I simply offer them for what they may be worth as a contribution to the general problem.

We have in the Toronto General Hospital a 760-bed hospital very closely associated with the medical faculty of the University of Toronto. All of the problems which I have cited confront us. We have set aside in the interest of a certain class of the community eighty-two private rooms, with rates ranging from $4.75 to $9.00 per day—the charge for suites is $17.00 per day. Generously considering the man of moderate means, we have set aside ninety-seven beds under the semi-private service, the rates being $3.50 and $4.00 per day. This accommodation is open to the profession at large and, as long as hospital rules and regulations are respected, the hospital does not, in any way, interfere with the treatment of these cases. To meet the demand of the profession, and also out of consideration of another class of the community, we have set aside forty-two beds under the classification of semi-public accommodation for the use of the general practitioner not on the staff of the hospital. This accommodation is offered at a rate of $2.75 per day, which is considerably less than the cost of the public ward service. It is intended to meet, or at least in part meet, the needs of the outside profession who have patients unable to pay the semi-private rate but who are not willing to submit themselves to clinical investigation and who wish to retain their own physician.

In addition to this we have a building devoted entirely to emergent surgery where the patients are given first aid on admission, pending the arrival of the patients' physician who is called with the least possible delay. The patient's physician may treat such emergent cases in the Emergency Department. When it becomes safe to move such patients they are transferred to the proper service in the hospital.

Out of a total of 760 beds, 241 are open to the profession at large, the remainder, consisting of public ward teaching service is under the direct control of the hospital and its own appointed staff and is used in connection with the clinical instruction of medical students. No outside physician may interfere in any way whatsoever with the treatment of patients assigned to this service. We do, however, welcome the presence of the outside physician at the time of operation upon patients whom

he has referred to the hospital and at clinics, if the case is one of special interest to him.

We have then in this way met the demand for the several classes of accommodation expected of us. We have, in part, met the demand of the profession at large—that it be permitted to follow its patients into the hospital. We have amply provided for uninterrupted clinical instruction to the medical student and, in my opinion, have met in reasonable proportions, the several community needs of a hospital.

With reference to the question of appointments to the hospital staff: I do not need to tell you that this is a source of great worry to the average trustee board and often the cause of much feeling on the part of some aspirants to hospital appointments. Hospital appointments should be protected in every way against prejudice, partiality, and political or financial influence. The hospital staff physician must be highly qualified, not only as an instructor and demonstrator, but as one competent in giving the best possible treatment to the cases in his care. However, the university is very much concerned in all staff appointments and should have an opportunity of discussing the merits of the respective appointments. For this reason we may well ask the university to name a limited committee—say, three or four university representatives, forming a committee on staff appointments. All applicants may then apply or may be recommended to this joint committee of the university and the hospital. This committee receives recommendations and applications and considers them entirely upon merit, and, as a committee, makes recommendations to the hospital trustee board, placing before them, with their recommendations, a record of the qualifications of each nominee. Their report is received and carefully considered by the whole trustee board, who may safely make hospital appointments from this list. By this method you often save an individual hospital trustee or governor of the university from embarrassment when they are approached by influential friends. They are in a position to say that they alone have no power in the matter, and that appointments are made in the way which I have just described.

We have been dealing with problems of policy. Let us consider internal problems involving the relation of the profession to administration.

One of the greatest problems of every hospital executive is the promotion of understanding between administration and

profession. It is difficult to successfully impress upon the profession the fact that the board of trustees, which is, in the final analysis, the management and the financial support of the institution is imbued with an honest desire to serve. This is, in fact, their sole motive for engaging in this field of philanthropic endeavor. With this in mind then, it is only reasonable to assume that they are not only desirous but keen in every possible opportunity of improving their hospital service. The only compensation which they can derive from their service to the institution is the feeling of satisfaction which goes with the knowledge of having performed a humanitarian service in a highly efficient and commendable manner.

Years of experience enables the trustee board ofttimes to anticipate the final outcome of many schemes and agitations, sometimes involving a change in organization or system, and sincerely believing in their conclusions cannot always acquiesce with the wishes of the profession or some particular faculty of the profession. Again, more often, lack of finances will not permit them to immediately respond to advocations or requests from their professional staff. It is on such occasions difficult to impress upon the profession that it is not through any lack of sympathy in the work, but for reasons far beyond the control of the board or because it is not in the best interests of the whole plan that various requests cannot be met. Such lack of understanding is very often due to the failure of the board or the chief executive of the hospital to meet such situations in a sympathetic and tactful manner. Since all those engaged in hospital work have common interests at heart a policy of "cards up" pursued over a period of time is bound to promote a better understanding and feeling between the administration and the profession.

It has often been said that an institution, such as a hospital, must be governed by an iron hand. It depends entirely upon the interpretation of "iron hand." If ruling with an iron hand is interpreted as meaning in an autocratic manner, then the institution involved had better find a new way to govern its affairs. Strict execution of tried and proven principles and the adherence to sound systems are essential. There must, however, exist on the part of the trustee board or the executive officer of every such institution a willingness to receive individuals or deputations for the purpose of considering their representations upon any subject whatsoever. It is the duty, and usually within the scope of the competent and experi-

enced executive to listen sympathetically and to reason with such individuals or deputations to the point of amicable adjustment or solution of the problem at hand.

For instance: The radiologist appeals to the superintendent for the purchase of certain additional major equipment. He would like to meet this request without delay, but is mindful of a long list of other important necessities. The pathologist has six months before made known his needs involving considerable outlay of money. The surgical staff have called attention to the desirability of improving the lighting system in the operating rooms. Medicine has long felt the need of laboratory accommodation or a metabolic kitchen under efficient direction. There is a long list before you. These are matters which may well be discussed with your medical advisory board, to which I shall refer in a moment. To merely say "no," is not enough and promotes ill feeling between administration and the profession. Far better to say: "Gentlemen, as you know, our finances are limited and our demands numerous; here is a list which I have had before me for some time. I have at my disposal $.... (amount of money), let us consider how it shall be spent so as to meet the most urgent hospital needs."

In many hospitals the professional staff does not receive proper recognition. If they are to be held responsible for the professional treatment of the patients the hospital should give audience to any suggestions or grievances which the profession, as a whole, may have. There should be in every hospital a committee representing the professional staff. This committee should meet periodically, not less than once a month, for open and frank discussion on matters concerning the professional service within the hospital. If this committee has suggestions to make or criticisms to offer let them submit such to the superintendent in writing or at a meeting to which the superintendent may be invited for the purpose. If amicable adjustment of such problems or differences is not reached by this means then this committee should have access to the trustee board at its first next regular meeting.

In the case of the Toronto General Hospital the advisory board consists of the heads of the several departments, that is: surgery, medicine, oto-laryngology, gynecology and obstetrics, anesthetics and radiology; in fact, every faculty interested is represented. As the trustee board meets on the third Wednesday of each month, the advisory board meets on the third

Monday. Thus, any proposal made by the advisory board which requires the consent of the trustees may be dealt with without delay.

As a hospital is not operated for profit and is seldom, if ever, in possession of surplus operating funds, there is no business in which it is so essential that a dollar go the full distance. This responsibility rests with the business management. Volumes could be written on this subject—time will not permit me to deal with it in this paper. I will, however, at the request of Dr. McMechan, give you one or two instances which will illustrate how savings may be effected in the average hospital. Every artisan hand in the employ of the Toronto General Hospital is made to work to a schedule. He is given a time sheet to be filled in by him and handed to his chief, upon which he specifies the time spent on each job assigned to him during the day. On the back of that sheet he records the materials used by him on the job. When time and material are extended we have the cost of the job. These reports are checked with the work done and the superintendent must be well satisfied that the work was done at a considerable saving over the lowest contract tender for the job. I have in mind a painting job for which tenders were asked. The lowest tender quoted an average of $35.00 per room; our own painting department tendered on the same job at $22.00 per room. The work was completed at an average cost of $19.60 per room.

Again, too often, the requisitioning of supplies is entrusted to those who have charge of the distribution and who are responsible for the economical use of such supplies. Under our system each department's daily or weekly requirements are carefully worked out and at specific intervals a report of stock on hand goes to the department from whence the supplies are issued. For instance: In a service pantry serving sixty patients, the pantry nurse does not requisition for her daily supplies but rather reports to the dietary department the number of patients she has that day and gives an inventory of the supplies on hand. The dietary department then order on the stores to send the necessary supplies to the various service pantries. Under this plan we feel that we have a closer check on our supplies and we encourage economical distribution. In conclusion I should like a say a word regarding the hospital staff and its obligation to the hospital.

The staff of every hospital owes at least one thing to the hospital—that is, loyalty. This, regrettably, the hospital does

not always enjoy. Whatever ambitions the staff may harbor concerning the hospital, realization is for the most part, dependent upon the good-will of the community which the hospital serves. Practically every dollar for expansion or new major equipment is acquired through personal canvas by members of the trustee board, among their friends or prominent citizens. You may well imagine the feeling of a trustee who learns from a prospective subscriber that his inclination to support the work of the hospital has somewhat changed as the outcome of an interview with a member of the hospital staff. This has happened and too often. It is not always deliberate on the part of the individual who leaves this impression, but may be attributed to some grievance which the individual holds and which he is voicing at every opportunity. The professional staff may very often assist the trustee board by telling of the good work the hospital is doing and that it would undoubtedly do more were it not hampered by lack of finances. I am glad to say that in our institution, not infrequently, through the good offices of some member of our staff, we receive donations and bequests, either marked for specific purposes or to be used at the discretion of the trustees.

Society Proceedings

CONVENTION REPORT OF THE AMERICAN DIETETIC ASSOCIATION

The sixth annual convention of the American Dietetic Association was held in Indianapolis, Indiana, October 15th, 16th, and 17th, 1923. This was a most interesting and instructive meeting, and an excellent programme was enjoyed by dietitians and friends of dietetics present. There were representatives from hospitals and universities from all parts of the United States and from Canada. There were also a goodly number of dietitians from other fields of work; educational, dispensary, social service, and commercial representatives.

The meeting was opened at 10 a.m. on Monday by the president, Mrs. Octavia Hall Smillie, with a short welcoming greeting. Miss Effie Raitt, director of the School of Home Economics at the University of Washington, Seattle, Washington, then took charge of the session, as chairman of the Administrative Section. Her paper on "The Survey of the Present Status of Dietitian's work," will appear in this paper at a later date. It was a splendid piece of research, and will be read with interest by all deeply interested in hospital work.

Miss Annis Jewett, of the board of directors of the American Restaurant Association, spoke on "Qualities Necessary for Success in Commercial Food Work." Miss Jewett is an authority in this line of work, because she has attained her present status through successful application of the principles essential in this field of dietetics. "Food Service to Nurses" was presented by Harriet Wells, Brooklyn Hospital; Maude A. Perry, Montreal General Hospital, and Breta Luther Griem, formerly of Peter Brent Brigham Hospital. A short open discussion followed.

The afternoon session on Monday was in charge of Miss Amelia Lautz, chairman of the Section on Dieto-Therapy. Dr. Russell Wilder, of the Mayo Clinic, found a keenly interested group of dietitians when he addressed them on "How

May the Dietitian Best Co-operate with the Physician?" This paper will also be read with interest by physicians and hospital superintendents, as Dr. Wilder speaks from experience and not theory. Dr. Walters, of the Eli Lilly Company of Indianapolis, in a paper on "Insulin Treatment and its Relation to Dietetic Management of Diabetes Mellitus," spoke of the value of insulin, as well as the dangers in treatment of this disease. As everyone knows, it is one of the most wonderful discoveries of modern times. Miss Lautz gave a paper on "The Standardization of Technical Methods used in Dieto-Therapy." From questionnaires sent out during the year she learned of methods being used in some of the leading hospitals of the United States and Canada, but found that uniformity of methods was not practical in every hospital.

On Monday evening, the annual dinner meeting was held in the Chateau dining room of the Claypole Hotel. Short addresses were given by Mrs. Smillie, president of the Association, and by Miss Lulu Graves, honorary president. Dr. Charles P. Emerson, Dean of Indiana College of Medicine, in a much appreciated address, gave us a vision of a wonderful future for the dietitian. He told us that this field of work offers opportunities for young women of ability far in advance of anything yet attained. Miss Laura R. Logan, R. N. of the University of Cincinnati, president of the National League of Nursing Education, presented an interesting history of the origin and growth of this League.

Dr. Ruth Wheeler, of the University of Iowa Medical School, presided over the Tuesday morning meeting. Mrs. Huddleston and Anna E. Boller spoke on "Teaching Dieto-Therapy to Diabetic Patients." Mrs. Mary De Garno Bryan told of the work which she has done in insulin study, especially in mutual teaching of doctors and dietitians. Through this work large classes of doctors with or without hospital connection, were made acquainted with approved methods of treatment of diabetic patients. Dr. Wheeler spoke of teaching being done at Iowa State Hospital in connection with diet in nephritis and tuberculosis.

Following this discussion a few minutes were allowed to the representative of Knox gelatine, who spoke of the value of gelatine in infant feeding. Tuesday afternoon was devoted to sightseeing trips to Eli Lilly Co., and other places.

Dr. Louis H. Burlingham, of Barnes Hospital, St. Louis, gave the dietitians an outline of qualifications needed,

especially by the administrative dietitian, in his paper on "What does a Hospital Superintendent Expect of a Dietitian." Dr. Amy Daniels, of the University of Iowa, spoke on "How can the Home Economics College Improve the Preparatory Training of the Hospital Dietitian." The success of a dietitian in any hospital depends so much upon her university training that no subject is of more vital interest to hospitals, physicians, and dietitians than this one.

On Wednesday morning, October 17th, the meeting was in charge of Mrs. Gertrude Gates Mudge, chairman of the Section on Social Service. Many dietitians are finding this field of dietetics very attractive, and co-operation of physician, nurse and dietitian in this work is yielding gratifying results. Mrs. Mudge gave the results of a "Survey of Polish Dietaries" which was conducted during the past year in New York City, Chicago, Cleveland, Detroit, Pittsburg and New Bedford, Mass. Miss Margaret Sawyer, of the American Red Cross, told us about work being done by Red Cross nutritional workers in rural communities. Miss Fairfax Proudfit, of the Memphis General Hospital, gave us some insight into the work being done by the dietitian in the hospital clinic in this hospital.

Wednesday afternoon we were treated to a most interesting account of some of the experiences of Miss Abbie Marlatt, of the University of Wisconsin, during her year's leave of absence spent travelling in various parts of the world.

The business meeting of the association completed the afternoon's programme. Officers elected for next year were: President, Octavia Hall Smillie; 1st Vice-President, Effie Raitt, University of Washington; 2nd Vice-President, Rose Straka, Presbyterian Hospital, Chicago; Corresponding Secretary, Breta Luther Griem, Nutritional Worker in Schools of Milwaukee; Executive Secretary and Treasurer, Anna Boller, Central Free Dispensary, Chicago.

The following were elected section chairmen and members of executive committee:

Administration: Maude A. Perry, Montreal General Hospital; Dieto-Therapy: Amelia Lautz, Peter Brent Brigham Hospital, Boston; Education: Dr. Ruth Wheeler, Prof. Nutrition, Iowa University. Social Service: Gertrude Gates Mudge. A reception and tea followed this session.

Wednesday evening, Lydia Roberts, of the University of Chicago, gave a most interesting paper on "Findings in a Dietary Study of a Day Nursery." From this one could see

that unless great care was taken to see that each child received and ate his or her daily allowance, per capita allowances would not be correctly adjusted by children themselves. Mabel Little, of the University of Wisconsin, told us of her work in "The Feeding of the Student Body, a University Problem."

The association had made arrangements for an inspection trip to West Lafayette, Indiana, to visit the splendid new and modern Home Economic Building of Purdue University. On account of a rainy day, and because some of the members seemed unaware of the trip, only about twenty took advantage of this opportunity, but all of these expressed appreciation of their reception at Purdue. Luncheon was served in the cafeteria.

The exhibits at the convention were instructive and well arranged. The dietitians availed themselves of the opportunity to get acquainted with both products and representatives of the different companies. The educational exhibit, arranged by Miss Mary Davis, deserves much approbation.

Adjournment of the association found the members unanimously agreed that they had enjoyed a fruitful and beneficial meeting. Recognition and approval of the work of the dietitian by both physicians and hospital superintendents encourage us to greater progress and achievement.

ALBERTA HOSPITAL CONVENTION HELD AT AL AZHAR TEMPLE, CALGARY, SEPT. 6th and 7th, 1923

The meeting was called to order 10.10 a.m., with Rev. Father Cameron, president, in the chair. Minutes of the previous meeting were read by Mr. S. B. Williams.

Mr. Williams: Shall I read the names of those attending the 1922 convention?

Dr. Smith: I would move that the names be taken as read. Carried.

Chairman: What is your pleasure with regard to the minutes of the General Meeting?

Moved by Mr. Stacey (Morrin), Seconded by Mr. Dutton (Lethbridge), "That the minutes as read be adopted." Carried.

The secretary then read the minutes of the Executive Committee Meeting held at the Macdonald Hotel, Edmonton, 1922.

CHAIRMAN: That is a true report of the Executive Meeting. We were not able to get the College of Surgeons to get medical men to address this convention as we failed to get them to move their date from Edmonton to here, so we have held our meeting with the Medical Association. I see the next item is the appointment of a Nominating Committee by the Chair. I am to appoint five. I will appoint Dr. Smith of Edmonton, Mr. Dutton of Lethbridge, Dr. McLeod of Medicine Hat, and Mrs. Melrose of Edmonton, and Mr. Williams, secretary. There is a Resolution Committee to be appointed. I think probably the Nominating Committee could report the Resolutions Committee this afternoon. Would that be agreeable? We might then have some more delegates to choose from. The Legislative Committee, I might explain, was to follow up these resolutions that we passed at the meeting last year and see they were properly presented to the Government. We saw the Minister twice last year and I think this year in order to have the thing carried out better we should have a Legislative Committee in or near Edmonton, that would be there during the time of the Session of the House. What does the meeting think about that resolution with regard to the Legislative Committee? It is very difficult to get a Committee to meet together just at the time that they should be there to see the Minister.

MR. STACY: How many is it usual to have on that committee?

CHAIRMAN: Three.

MR. STACY: I think it is a good idea to have three.

CHAIRMAN: I appoint Dr. Smith chairman of that committee, with power to select.

DR. SMITH: I think last year that the fact that that committee was a representative committee from all over the Province when it waited on members of the Government, had certainly some effect on the situation. We did not get what we wanted. They did later attempt to amend the Act and put in a few little words that have helped some, but to make any impression on the Government, Mr. Chairman, I think it necessary to have a pretty representative committee to go at least once to the Government to state the case if it can be arranged in some way. Last year you remember we got together at a time when you were up, Father Cameron, and thought some time we could work out a scheme of that kind. Personally, I would like to see a representative committee.

There are outlying problems which I think are very real problems and I think at present it would be very difficult for a local committee at Edmonton to put up at all properly.

MR. STACEY: I think it costly to have a Legislative Committee that certainly cannot be expected to meet more than twice a year and it is altogether probable not able to meet at the opportune time in Edmonton. I think it would be a good idea to try having a Legislative Committee at Edmonton who could meet several times during the year and take the opportune time to present their ideas to the Government. I think just what Dr. Smith has said. I think the Government will realize that these three men living in Edmonton represent the hospitals of the Province just as much as if men were present from different parts of the Province.

DELEGATE: I agree with Dr. Smith with regard to having representatives from all over the Province. Sometimes the representatives up at the House take more notice of it if the representatives are scattered all over. It is going to be a little expensive, but if we get results, what about the expense?

CHAIRMAN: We will never get all we want and we will never get anything if we do not go after it.

DR. SMITH: One result was the raising to large hospitals of the Workmen's Compensation Board rates which was quite appreciable.

MR. DUTTON: We feel in Lethbridge that the matter of a Legislative Committee is one of the most important in connection with our problems, as all our problems seem to be our relationship with the Department of Public Health, and I think it might be a good idea to have the personnel of that committee scattered over different parts of the Province.

CHAIRMAN: The meeting is open for nominations for the Legislative Committee?

DR. SMITH: I nominate Mr. Stacey of Medicine Hat. Seconded by Mr. Williams.

MR. STACEY: I shall have to ask to withdraw as I cannot devote the time that committee should devote to these matters.

CHAIRMAN: I think you should be able to get to two meetings.

MR. STACEY: I do not think it is necessary to have a Legislative Committee picked from various parts of the Province.

CHAIRMAN: Will some one move that this committee be selected from Edmonton or the whole Province. (Motion put by Chair). "Those in favor of representatives from the whole Provinces." Carried.

DR. SMITH: I would like to suggest it consist of five members, two from the outlying parts and three from Edmonton and district so that in case of an emergency arising there could be a committee meeting there to take any action, and the whole committee could probably get together once or twice in the year, certainly once. I will make that a motion. Seconded by Mr. Dutton.

CHAIRMAN: It is moved that this committee consist of five members, three from Edmonton or vicinity, and two from the Province at large. Carried.

Legislative Committee: Dr. Smith, Edmonton; Mr. Stacey, Medicine Hat; Mr. Dutton, Lethbridge; Dr. Archer, Lamont; W. T. Henry, chairman, Hospital Board, Edmonton.

AFTERNOON SESSION, SEPT. 6TH, 1923.

CHAIRMAN: Before asking Mr. Williams to read the interim report on the financial state of the society, I just want to say for the executive committee that you put a great deal of business on our hands last year and we did not shirk the responsibility. We worked as hard as we could. We had a number of resolutions to present to the Minister of Health, and we were most affably received by him on all occasions. We did not get all the demands we made, but I think probably a very good relationship is established now, and if the matter is pursued and very carefully put before the department that as we get on we will get more and more of the things we feel as hospital people should be considered by him and amended in consideration of the interests of the Province.

This is the fifth annual convention of a new organization in the Province and we must not expect too much from it and should not be discouraged if we do not get all we want at one time. In the work of the last five years much has been done for the benefit of the patient which is really the object and purpose of a hospital. Everyone, I think, in hospital work today, realizes more than they did before that although a hospital in a way is an economic institution and must be self-sustaining, the spirit which animates the body must be one of service, must be one which actuates people who are working, not so much for the institution as the patient, and I think we can

say to-day, safely, that in most of our hospitals all over the Province everybody is on the *qui vive* in the interest of the one who is ill, and unable to help himself physically and economically and when everyone does this and is ready for the call to duty, then we can say that everything is quite safe in the system.

There are many difficulties we will have to attack. If there is any fault in the procedure of our organization it is that we have been paying too much attention to the internal economy of the hospital, making the hospital a good hospital and an efficient one and that theory has been restricted to the city hospital and the larger rural hospitals. I think, however, the time has come when we should make an effort to get a larger membership and try to enthuse those who are not interested in standardization, in the work of building up efficient units of hospital; we should try to make them see that in interesting themselves they are benefiting themselves. Once a hospital establishes a reputation for efficiency it has won its place in the affection and interest of the people, and that means prosperity for itself.

Last year we had a new organization in the hospital world. The municipal hospitals organized an association and just at present it looks as if it might be a difficult matter to get together in working harness. When the organization was formed in the city here I responded to an invitation to say a few words to them, promising our interest in their work because they have special problems which they can solve better by organization. On the other hand there is much more to a hospital than the matter of dollars and cents and I think we are too small a body and have too many common problems to separate ourselves into two bodies with no system and little co-operation, and that point of view I tried to put before that body and it was kindly received by them. It is with that point of view, as members of a general hospital organization, we should carry on an educational propaganda during the coming years.

The work we have done in building up the internal economy of the hospital is in a pretty fair way to carry itself on by its own momentum, but if our interest and understanding of how to make a hospital effective has to be restricted to the larger hospitals, and if the experience the larger hospitals have gained cannot be handed on to the smaller

ones, then I do not think we as an organization are doing our duty.

I do not wish to dictate to the new body of officers what their policy should be, but I do think the great need to-day is an educational campaign. Although the organization is comprised of the larger hospitals and although it is its bounden duty to look after their interests, it is, nevertheless, not a selfish organization, but down at the bottom the interest of the patient is at all times foremost and if that is clearly put before them I do not see why some sort of working arrangement cannot be made with the Municipal Hospital Organization. We have, of course, as many members now belonging to this Association from the municipal hospitals. We are not losing membership with them, but we are not gaining it, and I think that we should.

In regard to our year's work I think the treasurer has prepared a report which he will read to you. The only thing, from a strictly financial point of view, that we have achieved was the fact that the Workmen's Compensation Board raised their rate, which did a little to help the hospitals. They raised the price per day per bed fifty cents. Up to that time the allotment did not come near to covering the expenditure on emergency cases, because in many cases for the Compensation Board, the whole allotment was used up in supplying bandages and immediate necessities of the patient and nothing was left for the daily upkeep. Under the new arrangement the hospitals which receive these patients will receive a little better remuneration.

I will ask the treasurer now to read his interim report. This is an interim report, as you will understand the greater part of our expenses will be connected with this Convention.

TREASURER: This is an abstract statement of receipts and disbursements and the expenses since my taking over from the last executive on November 27th (Reads report of receipts and disbursements.) There will be a few more expenses and one or two receipts. One was received to-day. Under the present arrangements we received a portion of the receipts in connection with the exhibits.

I beg to submit for your consideration my report as secretary-treasurer of the Association for the current year. An interim financial statement is given herewith, it being pointed out that the further receipts and disbursements in connection with this convention come under my accounting.

Our president, Father Cameron, will, I am sure, deal with matters pertaining to policy, but I cannot refrain from mentioning one regrettable incident which has taken place in connection with hospital work during the past year in the Province. This is the severance of their connection with us of a number of the municipal hospitals, these institutions having formed an association of their own known as the Alberta Municipal Hospital Association.

You will remember that last year's executive did all in their power to make the municipal hospitals and county hospitals feel that their co-operation was desired and needed by our Association.

The Alberta Hospital Association stands for the development and betterment of all hospitals, not only city institutions, but country and municipal. Are the municipal hospitals so perfect of organization, so self-contained, so much above reproach that they can afford to completely ignore the co-fellowship of larger, and in many cases, better equipped institutions who are doing the same work as themselves?

I would urge on the incoming executive of this Association the necessity of undertaking educative work along the lines of our aims and aspirations. I firmly believe that there is an undercurrent of thought in this Province which would be glad to see the Alberta Hospitals Association non-existent. Let us all put our shoulders to the wheel and refuse discouragement. Let us bear in mind that if we have small numbers this year there are two serious factors working against us, the necessity of getting in the crops, and the Alberta Municipal Hospital Association. I would also urge that a date be set for these conventions when country members have the time at their disposal to attend them.

It has been a pleasure to serve you as secretary-treasurer. We have done our best to produce an educative programme at this Convention, bearing in mind the fact that our executive is scattered throughout the Province.

Our membership shows an increase from last year's lists.

Respectfully submitted,

S. P. Williams, secretary-treasurer,
Alberta Hospital Association.

CHAIRMAN: I suppose that as the financial report is an interim report that adoption is scarcely in order. Does anyone wish to speak to this?

Moved and seconded, that the treasurer's report be received. Carried.

CHAIRMAN: Mayor Webster has gone away on a vacation and evidently taken his talk on "Hospital Finance" with him and we have to take the second paper on our programme. Mr. Christie is here to tell us something about running a laundry, with as little expense as possible.

"HOSPITAL LAUNDRY PROBLEMS."

Mr. Christie, Canadian Laundrymen's Association.

Mr. Chairman, Ladies and Gentlemen:

It is expense all the time. It is one of the things you cannot get away from, the enormous expense. Too many people outside of those really interested in laundry work know nothing of the expense there is in connection with a laundry and the running of it in an up-to-date manner.

I do not come to-day prepared to tell you how we have run our laundry. We have worked hard at it and that is the only way you can get along in running a laundry. We have had some experience in hospital laundry in Calgary. In the Calgary General Hospital a few years ago we undertook to do the laundry work and furnish all help and we did it for nearly two years.

There is one thing from a laundry standpoint as against the people who collect the things. There is not enough co-operation between the matrons, nurses and orderlies in the hospital and the laundry. I have seen linen all piled together, everything from the beds, operating room and everywhere else and by the time it is ready for the washer nobody knows which is the dirtiest or which the cleanest, and we have proved it is a big loss to the institution to put all the laundry work together. If you get it separate, the operating room, the bed linen and so on sorted upstairs some pieces may take a little more washing than others, but if you get it all together the consequence is that the cleaner linen gets twice as much washing as is necessary in order that the dirtiest piece in the lot may get sufficient washing to make it clean.

Another point: I do not think there is enough co-operation between the staff in the hospital and the staff in the laundry. I think that both have their troubles, there is no question about it. They are down there in the laundry doing their best, and if they get the support from the rest of the institution they can give that institution better service.

I am not going to tell you how to take hold of a bundle and wash it, as my end of the work is the office end, but I think if you are interested in seeing laundry work done the best thing would be to pay a visit to the large city laundries and the washman there or the help there will give all the information it is in their power to give. Our own plant is open for inspection by any person, and especially by any person interested in the laundry business.

There is a peak load in the laundry business. We have the capacity for handling so much, we have the help trained to do that amount of work, and it is wonderful how little help you have to have to get through, but if you get beyond that, say fifty per cent. or thirty-three and one-third per cent., you then have to start increasing your staff. You are starting in with expense right away; you have expense there to take care of. We have found in our business that the next week perhaps, might be a slack week. You are up against the proposition of having extra help around the institution and nothing for them to do. That is the hardest thing to control in the laundry business, and in the hospital work it is just the same, you will have weeks and months when you are busy and then an off time. When you are busy put help in and as soon as you get slack you have got to cut that help off. There is no use figuring that next week is going to be a good week. You are carrying expense, something positive against the hope of getting more to do.

In our case since the summer of 1915, it was impossible to get men to do washing, so we took off our floor several girls who wanted to earn more money and we gave them wash-room jobs. We found quite a little trouble to get girls to put on overalls and rubber boots and do that work, but after we got the first gang working with my brother on the floor for a month or so they demonstrated that it was just as easy to do wash-room work as some of the other work, and we have never gone back to men for washing. We think that women, after you have taught them to run the machines, have a better idea of washing and turning out good work, and there is no doubt that they are just as good and in some cases a lot better than the men.

I do not know what I can tell you in the way of handling these linens except to repeat that I think the linens going to the wash-room should be sorted and not all piled together. There are certain chemicals used around an operating room

that do burn up the sheets and these sheets could be used again for that same purpose, and where they burn a hole in one sheet to-day that sheet can be used again to-morrow with that hole in it, but if it goes back for use in the wards, to-morrow you will have another sheet with a hole burned in it, and you will have dozens and dozens with holes burned in them or with stains that cannot be taken out in the ordinary process.

I would like to say that if you cannot come to our laundry if you would care to write us a letter and tell us your troubles at any time we will be only too pleased to furnish you with any information we can.

I cannot tell you anything about sanitation. The doctors should be teaching that to us and not us to them, but in the laundry business the trouble is to get good help and to know how to do it, so you will know whether the work is being done as it should be done.

CHAIRMAN: Mr. Christie has given us a very interesting paper and the greatest praise we can give it is that it is very practical. Are there any questions?

MR. WILLIAMS: I would ask in a small hospital, say forty to fifty beds, do you think it an advantage to install their own laundry, that is in a place where a good steam laundry is not available? Do you think it beneficial in a financial way for them to do their own laundry? In other words, do you think it good policy for the hospital to send washing out to general charwomen or Chinamen if necessary?

MR. CHRISTIE: There is always a prejudice against any public laundry doing hospital work. Personally, I do not think there is anything to it. We have done hospital work for outside places. We had Drumheller and Red Deer, but the only trouble with stuff from outside points is the express charges. It is almost impossible to put any common sense into the express companies. I have tried to talk them into the amount of work that could be done with a reasonable rate. Answering your question as to whether an institution should have a laundry: I think it is almost a necessity in Drumheller and these other small places. It is almost impossible for them to do without a small laundry. I do not think there is any necessity to have a high price laundryman. If you can break in help there are formulas for doing that class of work. It is harder to handle woollens because if there is lots of steam and hot and cold water to hand they are liable to use too much of

it, but if they use reasonable discretion there is nothing to it. Some big hotels have their own plants, but for ordinary institutions and small hospitals, I think it is preferable to have a small plant. It is not necessary to have too expensive a plant. Many institutions think they should have a plant that is fit for a king, but we have nothing but wood washers. I would like to buy brass cylinders, but it runs the expense too high. There is too much money often wasted. In the big public laundry where they do steamship work or train work, brass cylinders are necessary, as they work a capacity of ten hours a day. You work a tub in a hospital an hour or so a day.

Dr. Smith: We have enjoyed very much the address of Mr. Christie. Those who are interested in hospital work have often found that not only the nurse, but more particularly the doctors are big sinners in the way of abusing laundry. In the operating room the doctor is very free in the use of iodine and daubs it over everything. The next morning the laundry comes up with half a dozen towels and a sheet which covers the whole table with a stain of iodine right in the middle of it. The doctors do not realize that in taking that out it is very liable to damage the fabric and our medical men should have their attention drawn to this.

Dr. Laidlaw: I would like to get some idea of the wages paid for laundry work. What wages are paid?

Mr. Christie: The minimum wage covers everything in the laundry line. It was to be $14.00, but it was not put into effect on account of the chairman resigning his position as deputy attorney and there has not been another chairman appointed.

Dr. Laidlaw: What is the wage for a head laundress?

Mr. Christie: I have had the question asked: "what do you pay your head girl, your head ironers, your head checkers?" and so on. Why have all these heads? If you are there to look after it you ought to have the ability to be head. We have girls earning $20.00 a week on the wash-floor, and I think it is $9.00 they start in at now. We did start at $10.00 previous to the minimum wage. We have started to adopt the piece-work system whereby they are paid on the basis of the amount the crowd handle. The war shot these things all to pieces and we have not gone back to the piece-work.

"Hospital Records."

Mrs. L. deStage, R.N.

Mr. Chairman, Ladies and Gentlemen:

I am not going to give a paper, but will try to explain very plainly how we keep the records in our hospital. You are all talking about co-operation. There is nothing in the hospital that needs co-operation more than record keeping. So much depends on the doctor, so much on the nurse and so much on the heads of floors to get perfect record keeping, and I mean to say when any doctor, any government inspector or anybody who has to do with a patient's future requires it we can give that information at once, and not say "I will give you that information to-morrow, or call up in an hour or two."

To give information at once we have to have a system whereby we can put our finger on it, whether the patient was here five years ago or as late as yesterday. I have made out a routine copy of how we admit patients. The patient comes into the office and we take all the information in duplicate, and here is a copy of the table (exhibiting). First, the name, nationality, age, religion, occupation, doctor, husband's name if lady, or nearest relative and their occupation with their phone number.

The duplicate is then taken to the records office. We admit the patient in one office, walk through and put this table on the desk in the records office, leaving the original sheet in the day book with exactly the same information. Then the record keeper takes the patient to the floor with a little card, and on the card is written the patient's full name, religion, and doctor's name.

While talking about the patients you will see the record number is 39001. To the ordinary observer that means nothing, but to us it means the year, month and order in which they were admitted. Three for 1923, 9 for September and 1 for the first patient in the month. Therefore this patient is the first patient admitted in September, 1923. We do not need the name or anything else, we have that number. This number follows the patient. This number is put on the card, so the first thing the nurses do is to put the number on the nurse's chart and every sheet belonging to the patient's chart is supposed to have that number on it. That number is carried right through. If the patient is unable to come to

the office they are looked after by the staff and a summary card is made in the records office and taken around to be completed after a reasonable time, and on the card is all the information necessary for this duplicate file: name, address, age, single, married, widow, doctor's name, etc., and case record number, and this is put on the back of the chart and left there until the patient is discharged. When discharged the chart is brought down to the office in this manner. When the patient is shown as discharged the doctor has to fill in the final diagnosis, working diagnosis and any existing condition, and the name of the doctor giving the anesthetic; when discharged, whether cured, incurable or dying, and the card is signed by the doctor attending the case. When this card comes in to the office we have the case history filed under the number opposite, given complete with operating reports, post operating reports, urinanalysis, and so on, then the nurse's chart starting with the date of admittance and ending with the date of discharge and lastly the doctor's card. These are all put in order and glued together. At one time we used to just clip them together, but we found in the handling of case-records the doctors have not the time to be very particular and do not always watch for little things and sometimes lose a page, but if they are glued together we save the doctor trouble, and then when they go to staff meetings or to the doctor's room to be discussed, everything is there with all the necessary information and it comes back just as we sent it, and, therefore, there is no trouble with lost pages. The card is taken away from the chart proper and put here, put in a folder and the name of the patient with the record number is put on file.

This is a diagram of a filing cabinet for the four current months. This chart is put into the drawer. This is the February chart, and it will be put into the February drawer under the initial of the patient; here the number has nothing to do with it.

Then we take the card and start cross filing. This patient was operated on for acute appendicitis, stayed in the hospital fourteen days and was discharged. We take a card from the drawer marked "diseases." We take a card marked "acute appendicitis," 1923, and we take this patient's number: 9001. We put on this card "F" for February, 3 for 1923, 9 for September. One means this is the first patient admitted. If the number was 324 it would mean that 324 had been admitted

during the month so far, so the last three figures stand for the number of patients. If we have ten cured patients and somebody says what is the average stay, we simply have to add up the total number of days and give the average, so that is why we keep the number of days the patient stays in.

You will see on this card red figures. That means the patient had a complication after admittance. In this case infection followed by death. F3016. That means this patient was admitted and she died, so her number goes into the dead file. This (indicating) goes to the drawer for operations and here again we put the number 900114 and these cards are put in these drawers in order under the initial.

Complication: I take another card "infections." Now, if the patient comes in with infection you would not see the "C." When there is a "C" it means a complication so this patient's number is to go under this card as the infection occurred after admittance. We have three drawers at the top and three sets of drawers for cross filing. If the doctor says he does not remember the name, but defines the case, I take one of these small cards and find the number; get the case and look it up in the book and give him the name of his patient. When finished with these three small cards we take over the doctor's cards and they are all put together. There (indicating) is the doctor, name, month, year, total number of cases, surgical, medical, obstetrical, and here are the details of how discharged. Unless the doctors fill in the cards we cannot keep records and, therefore, we keep after them and nowadays we do not have very much trouble, and when a doctor wants to know about his own case the information is easily given. This is put in a drawer marked "summary card." This gives us four months for files for patients, and one year for cross filing and summary cards, and at the end of four months we transfer to large transfer cases. At the end of the year we transfer to other transfer cases, so we start afresh with an empty cabinet for January, 1924.

We keep an index, but have to know how many patients and how handled, so here we have a monthly card. As we put this chart away we take three cards about the same size as the summary cards, one surgical, one medical and one obstetrical and every case is put on that card for the month and at the end of the month we add up all surgical, medical and obstetrical cases and these numbers have to tally with the number of cases we have discharged and by doing that

we can tell at any moment, how many surgical, how many medical and how many obstetrical cases we have discharged. These cards are kept for a month. We would have twelve for surgical, twelve for medical and twelve for obstetrical. We have another card which we make out and which we call the yearly card and this is filled in every month from the monthly card giving the total number of cured, inmate, and died, and at the end of twelve months you have the report for the year. That yearly card gives you at a glance an outline of the work that has been done, and it is all done in detail. These are added at the end of the month, and at the end of the twelve months it is an easy matter to add it up.

We take our books and we take our admittance sheet and that is put with the patient's chart right on the back, if the account is paid. If not we keep it out as the account is on the back. When we put it away we know that the account is paid. If not we keep it in a book by itself and all our unpaid accounts are in one book. Before putting our files away we have to have an index so we keep it with the December chart and in that index we have the patient's name, the record number, the day they were admitted, the day they were discharged and whether in a ward, semi-private or private room. In that we can find anything we want to find. If we have the number and not the name we can go to the drawer and find it; if we have the name and no number we can look for the name and find the number and go to the drawer. That book is the key for the whole year. When we want to know anything about any patient and their account has been paid it is here filed away all together. If the doctor wants to trace all cases of peritonitis for the last three years, go to the disease drawer for three years, take the numbers of all peritonitis cases and from the numbers get the names and we can go right to the drawer and get our case. It is not a system which takes a long time. It is very simple, but needs the co-operation of the doctor, the nurse and the heads of the floors. Co-operation should be the key-note of the whole record system.

CHAIRMAN: I am sure that is very interesting to all those at work in hospitals, and should be of particular interest to those who have to get our Government reports. I would like to ask Mrs. deSatge whether she is able from this system to prepare the reports within the space of a week or fortnight. It is made out definitely to answer these reports?

MRS. DESATGE: We make the Government reports from the summary reports. We have all names, and patients discharged, in the summary cards and at the end of every month they are put in order and report made from the summary cards.

QUESTION: How long would it take in a hospital of 100 beds to make your monthly report?

MRS. DESATGE: If you have only 100 patients it would only take a couple of hours.

DR. LAIDLAW: Is there anything you could do to simplify these reports?

MRS. DESATGE: Well, I would like to talk to the Minister about that.

DR. ARCHER: I think we are very much indebted for this excellent paper. The first thing that impresses itself on me is that it is not complicated. I am a doctor and all I do is go and ask for what I want and it has to come, and come in a hurry. We never know where it comes from, but I can see when you explain the simplicity of it. I am attending the hospital regularly and Mrs. deSatge seems to run all these case records in the Holy Cross, and besides has time to attend to the books, and office work and I see her attending to the general business and banking and then if we really want to keep her working we take her upstairs and put her nursing. The fact is when the system is started it must be very simple to carry it out. I would like to say in connection with the rural and smaller hospitals they are getting more system and better systems in connection with case records, and from what I have observed during the past year a very enviable step forward has been taken; I think there is room for improvement still. The hospital secretary is the man in the smaller hospital who will have to insist upon the record being made one hundred per cent., and one of the difficulties, of course, is a little friction between the officials and the doctor in that regard, but I do think case records of such importance that the hospital should take a decided stand that the physician must prepare and complete one hundred per cent. of their case records. When I am compelled, as I am now, to prepare a proper case history, I am compelled to write my directions, compelled to follow out the whole routine, and I know my patients get better care, more concentrated attention on that particular case and consequently your hospital handling so many cases, will give far better assistance, due to the records.

Where the system is followed out in a small way as in the smaller hospital I am satisfied it is a benefit to all those carrying on the work. The doctor who is checked up by the nurse, the nurse who is checked up by the nurse or sister in charge, who is again checked up by the secretary or superintendent in charge, will all benefit by the checking up of each other.

MR. DUTTON: There is a question I would like to ask. It was stated that the system helped to fulfil the requirements of the Public Health Department. I am not clear on one point. My difficulty has been to keep our records up in accordance with what the Department requires owing to changes being continually made. Do I understand that the numbers change every month, that you start off again from No. 1 each month?

MRS. DESATGE: Yes, from No. 1. January starts with 1000. December starts with 12001. When making Government reports we do not use our record number, but the record number is really for the use of keeping our charts.

MR. DUTTON: The number you report to the Government is not really the record number. I want to cite an example. I have been acting as secretary and returning my reports to the Provincial Government I used the original number of the patient. I got my returns back from the supervisor of organization with the information that the numbers of any patient after December 31st, should be renumbered, which really means we have to show two numbers on a lot of occasions for the same patient.

CHAIRMAN: Do you consider that has any particular advantage from the point of view of the Department. What particular information does the Department get by the renumbering of the patients. Is it a necessary piece of work to be done?

DR. LAIDLAW: We think it necessary at the present time. Our yearly records are kept separate and we pay on that basis. I shall be glad of any suggestions that will simplify the work of the secretaries.

CHAIRMAN: In the first place this seemed to be such a complete and comprehensive system, but while listening I was much struck by the attention paid by each hospital here, because mostly everyone started to work out their own system and, therefore, have as many different systems as there are different hospitals and then the Government comes along and brings a brand-new system into effect without any consideration of the work that has been done for months and months

and years. It might not be possible to do so, but I would not think it a foolish suggestion to throw out that the Government call together the secretaries of the different hospitals and have a uniform system. Probably there would be some little changes from those that are now in force, making them all alike and so that they would suit the Government records. I would think that would save a great deal of time and that is economy in hospital work and at the end of the month it should be an easy matter for all hospitals to have a uniform scheme of presenting their reports to the Government. I am sure if all hospitals worked so industriously and systematically in working our record schemes as the one presented to-day —and more will have to do so in the future—we might well save time by consulting.

Dr. Laidlaw: If this return is at all a charge on the time of the secretaries we will be glad to take it up. The reason we ask the hospitals for monthly reports is that before we used to get the whole six months returns in together and it took a long time to check these up. In many cases the cheque issued on the Government grant was not paid for many months after returns were sent in. With these reports as they are now the majority of the cheques go out in reasonable time and we did that by putting in a supervisor of organization so he could go into these matters and it was felt he could give that matter some attention and bring in a system which would be much simpler than it has been in the past. I shall be glad to bring that matter to the attention of the Minister.

Chairman: I must say that this system has been noticed by pretty nearly everyone who visits the hospital.

We had Mayor Webster to talk to us on the matter of hospital finance, but he has gone out of the city and evidently taken his address with him and I have called on my friend Dr. Crawford, to come to the meeting and fill the breach.

"Hospital Finance"

Dr. Crawford.

I am not prepared to give you anything like a reasonable paper or a reasonable address on this matter. I knew nothing about this until ten o'clock this morning and the result is I have brought together a few ideas simply to start discussion and that is all I am prepared to do.

A general hospital must be conducted on regular business principles. A hospital is not established primarily as a money-making institution. Nobody expects to make any money out of a hospital. They are simply established to fill a want, to take care of our sick in the best way they can. In order to properly finance the institution we must try to keep receipts as near expenditures as possible or get expenditures down to where receipts are, so that the difference will be as little as possible. Now I would suggest in the beginning, one way to get receipts up would be a careful grading of service in the hospital. Most hospitals are accustomed to grade as general, semi-private and private. I would sub-divide some of these. I would have these different services at different rates so you would be able to supply a want that practically any person is able to pay for. If a patient comes who is able to pay $3.00 or $4.00 per day it is better to get that than to give them private accommodation at $5.00 a day and lose the difference. A great many people have been in hard financial circumstances and we have had a great demand in all hospitals for general wards and that is accommodation as cheap as we can make it. I believe that will pass away if we get times any better, but there are always people not able to pay anything or just a little. I think hospitals should try to have as many beds as possible either free or at a minimum charge to meet these demands. I would also have emergency beds to put in temporarily and when patients require accommodation I would like to have them tucked away somewhere rather than refused accommodation altogether. We find in some hospitals if we ask for a semi-private or general ward they just say they have not it. That is all right, but I believe an effort should be made by the hospital to tuck the patient in some place for a day or two and thus you keep the patient and also the friends interested. If the hospital turns that patient away they lose the connection with the patient and his friends.

Now the service that should be rendered I feel should be along the line of different service for different prices so that we are not running into debt giving elaborate service to people who do not get it at home and cannot pay for it.

Another thing, I would like to have all patients absolutely understand what the charges are before being admitted. Some patients are under the impression that they are paying $2.00 a day and then get a bill for a lot of extras. That makes the

patient dissatisfied and maybe a little bit sore as he thinks he is being overcharged, and, therefore, I would advise that the person who admits them should make known to them what that $2.00 a day covers and other things are extras, so the patient will understand.

Collections are a very hard thing to manage and it requires something of a diplomat to manage them and manage them successfully. There is somewhat of a tendency on the part of a section of the community to get away from paying bills to municipal institutions, more than private. The patient says "oh, the Government pays for it—the Province pays for it" and there is not much attempt made to dig up the money for this maintenance, consequently a definite system of collection should be established in all hospitals. Accounts should not be allowed to run for any length of time without arrangements as to when the account will be paid. I suppose in the West we suffer more from transients than in the older settled communities. We have transients who are here to-day and gone to-morrow, and they have to be looked after. I do not know that I have anything much to advise in the way of trying to get after these people other than a rigid system of collection.

Another thing is the chronic patient. We will have to bring more pressure on the Government so that old chronic patients can be looked after. Take most of our hospitals; they are expensive places with a lot of expensive equipment and service, and then we allow a large section of our hospitals to be taken over by chronic patients who are little better than boarders. I think these could be looked after much better where they do not have the expensive equipment tied up. There is the trouble also of a chronic when he knows he is not able to do much, having a tendency to hang round the hospital. I think that difficulty might be dealt with severely and strongly. I do not think our hospitals should be boarding places or places for these people to loaf in all winter. The municipality is responsible; I am under the impression the Government allows the municipality to be responsible for patients up to a certain amount. I feel that if the municipality is responsible up to $5.00 or $10.00 or $100.00, they should be responsible up to $200.00 or as long as it is necessary to take care of that patient sent from their municipality.

Expenditures: I do not think the staff should be too numerous, but specialized and well paid for what they do.

Numbers of staff does not mean efficiency. We should have highly specialized people to look after specialized things, but not have a whole lot of people around in each other's way. The same thing applies to the nursing and then I think we should have a specialist on purchasing, so familiar with the markets that he can take advantage of chances to buy any large quantities of supplies at a time and make the best of each purchase. Another place where I believe there could be a great saving is in having proper records of the stores and the laundry; I believe every article entering the laundry should be recorded and counted, otherwise a great deal of material can be slipped away from the laundry and passed into other hands and be lost to the hospital. The same way with the stores and supplies. Records should be thoroughly kept, so the management will know at any time where the supplies are going.

Labor-saving devices in large hospitals: In the power plant ash conveyors and coal conveyors should be installed wherever possible, to save labor. Another point is refrigeration; it will prevent waste of food and food supplies. Another thing that often runs away with a lot of money is an excessive amount of electric current when it is not needed. That is a thing that can be watched very closely. There are only a few things I have thought of and are only for the purpose of discussion. This is not meant to be a complete paper at all.

CHAIRMAN: We feel indebted to Dr. Crawford for coming here on such short notice. He has given us an interesting paper and covered a great many points and I am sure a number of you here will enter into the discussion.

DR. SMITH: One thing particularly occurred to me while Dr. Crawford was speaking and that is in connection with the relationship that at present exists between the hospital and the municipality for whom the hospital is working. I think it is a well-recognized fact that our municipalities, our country and our city municipalities are responsible or should be responsible for their own sick. Now the Province recognizes that to a certain extent, and I think the only hospital that the Province operates is the hospital for tuberculosis which draws patients from all the municipalities of this Province. In connection with that hospital the Province sees to it that each municipality from which they are received pays them for the service rendered to the patient, and they do not then ask the patient very much. I believe they refuse to

take money from the patients, but charge the bill back directly to the municipality from which the patient comes. It is a very strange thing to me that the Provincial Government take that attitude with regard to their own hospital, but when it comes to the other hospitals of the Province they refuse to allow the municipal or private hospital or religious bodies that operate these hospitals to take the same attitude to the patients which they receive. I am sorry that Dr. Laidlaw got away. There should be some member of the Municipal Hospital Department to hear these things. If the hospitals of this city could just get from the municipalities outside this city the accounts paid that they have opened I take it that they would have no trouble in financing; financing would be easy and it would be a pleasure to operate our hospitals. Why should it not be so? The Provincial Government set a splendid example and why should not any person say, "give us the right?" That is exactly what your executive urged them to do last winter. It is not possible, as Dr. Crawford well knows, for a hospital to refuse a patient admittance, no matter where the patient comes from. Humanitarian motives alone forbid refusing to take a patient in, but why should this city or municipal district of Drumheller be compelled to take in patients from all over the Province and not have any guarantee that they are ever going to be paid? I think, Mr. Chairman, that this is a matter we might very well continue to urge upon the provincial authorities. I was much interested in what Dr. Crawford had to say with reference to the various departments. I do not know how far the doctor is prepared to go in that. I quite agree with what he said with regard to not allowing patient's accounts to mount up without letting them know what the bill is. We have in the past year in our hospital been rendering every patient their account every two weeks. The patient gets his bill two weeks after he enters and gets it every two weeks up to the time he leaves. That has the effect of letting the patient know what his bill is, and when he leaves the hospital it is not a surprise to him. This whole question of hospital finance is rather a serious one. I do not know just what the solution of it is unless it be found through our Provincial Government. Certainly they might do a great deal more than they are doing to assist us in providing for the aged and for incurables and convalescents. Surely the time has come when we should have one or two homes where these people can be

taken care of properly and economically and the burden might very well be borne by the Province at large.

Mr. Stacey: As I see it as a humble member of the hospital board, not as a medical man, I fail to put my finger on any one thing more important than another. We know what our charges are and we think the charges will meet our contemplated expenditures, but where we fall down is the collection of the charges. We have collected a greater percentage the last few years than for years perhaps, but we have arrived at the point that most of the hospitals have arrived at, where we have had to take drastic steps. I find in talking to the various members of the boards that they will constantly repeat that it is not a business institution and that it must do a lot of work for a lot of people who cannot pay. That is all very true, but I think you will agree with me that we have the greatest delinquency among the class of people who could well pay. The people in very poor circumstances usually make the supreme effort, and I would suggest we do not repeat so often that the hospital is prepared to do a large amount of hospital work and, therefore, must not harass the patients in the hospitals, in other words, go carefully, but the fact that we have collected 66 2/3% as against about 53% of our charges in the four years previous to 1920 encourages me to believe that we might yet do better and run our hospitals more as a business institution. There is this about it, if we are going to give the fullest service to the public at large we must have money to pay for it and it is either going to come from the people of the Province as a whole or from those who have incurred the expense, and we must educate the people that they are going to pay for services in the hospital the same as in the shoe store or any other place where they do business or that they receive service from.

Mr. Dutton: It seems on this question of finance and more particularly, collection of accounts we can only keep on repeating what has been said in previous years. So far as my experience goes the only way is to make it very clear to the patient at the time of admittance what their obligation is, and if their circumstances are such as to be unable to meet the obligations, you are in possession of all the facts if you want to come back on those responsible for payment of these accounts which the patient cannot pay. We would be satisfied if we could get the muncipalities to pay up the amount that the Act provides. The Act is very evasive. Pa-

tients drift in from all municipalities; we take them in and they leave, and when we try to collect it is only in a small percentage of cases that we can get the municipality to recognize their responsibilities. That is a responsibility of the Provincial Government, which I claim they should recognize, but we fail to make them see it. If a patient comes from unorganized territory the responsible party is the Provincial Government, and it has been our custom to bill the Government, but although I have written and written they will reply that crop conditions look favorable and you must wait and see if the crop materializes and you can collect them. Why should the city hospital carry the burden of these cases? I claim that it is the responsibility of the Provincial Government.

CHAIRMAN: When we had our meeting with the Minister of Health he expressed his opinion that under the present system we are absolutely responsible and there was nothing to prevent any hospital collecting the bill. He also said there was no limit; that the limit put down in the Act was only the limit you could collect on account. You could collect $200.00 this year and if that did not cover the indebtedness you could collect again next year. Now, when we were talking to the Minister about an Act so indefinitely worded he gives us that interpretation and we find the municipality is solvent; I do not understand charging to the individual under those circumstances; I do not see what is to prevent an institution prosecuting to the full limit of the Act those who will not even recognize correspondence. If that can be done, and it is a reasonable thing to do, then I suppose if collection is not made the hospitals responsible are to blame.

(To be continued in our next issue)

News Items

TO BUILD NURSES' HOME

Superintendent Galbraith of the Western Hospital, Toronto, announced at the annual meeting of the women's board on December 4th, that plans are under way for the construction of a new nurses' home. The president, Dr. Augusta Stowe-Gullen, was presented with a beautiful bouquet of roses and lilies of the valley.

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The manufacturers of Fellows' Compound Syrup of Hypophosphites, 26 Christopher St., New York City, recently published the brochure above referred to. It is the result of a great deal of work and any physician who did not receive a copy should make prompt application to the firm. The brochure takes up the prevalence of cancer, its nature, origin and predisposing factors, the question whether cancer is local or general, its exciting causes, types, sites, symptoms, diagnosis, and treatment.

AN OLD FIRM UNDER A NEW NAME

A few months ago, the well-known firm Hudson-Parker, Ltd., became Corbett-Cowley, Ltd. It really is a change in name only, for Messrs. Corbett & Cowley have been in control for a considerable length of time, having been identified with the business since its inception, and it is under their management that the name Hudson-Parker has come to be identified with high-class hospital apparel and bedding. Both are practical men who understand what is required for hospital use, and have been inspired with the determination to make their product one to be proud of. Operating their own factory, they have featured the "Made-in-Canada" idea—not for the purpose of seeking business on sentimental or patriotic grounds, but to demonstrate that in the matter of quality, Canadian-made products can, and do, successfully compete with the best imported goods. The plan of selling direct to the hospitals has also been an important factor in the development of the business to its present standing. Ordering by mail has been made an easy matter, thus placing hospitals in the smaller cities on an equal footing with the larger institutions in the matter of purchasing their apparel and bedding. The business will be continued in the present quarters: the Darling Building, 96 Spadina Avenue, Toronto.

PEQUOT COTTONS

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For years there has been a well-defined desire by particular people for a hand and bath brush that could be absolutely relied upon to give real service measured in years. And at last such a brush has been developed. In the Hi-gen-ic Aluminum Rubber Set Hand and Bath Brush—a product of Canada's pioneer and leading brush makers, you have a brush to which there is practically no limit of serviceability. And it is a beautiful brush. Formed to fit the hand, its polished aluminum back harmonizes with the polished nickel fixtures of the modern bathroom. While costing a little more than an ordinary wood-back hand brush, the Hi-gen-ic Aluminum Hand and Bath Brush will give infinitely *better* and immeasurably *longer* service.

"Canada's Most Famous Dessert"



Institutional Size
makes one gallon

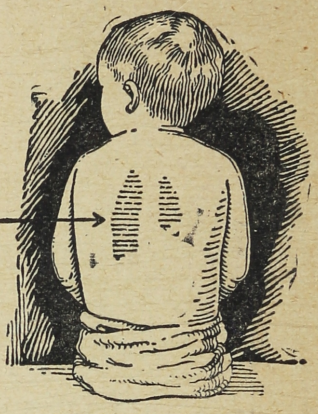
Packed in Two Sizes



Domestic Size
makes one pint

These two products are exactly the same except in size. The INSTITUTION that specifies JELL-O is assured of serving its patrons with exactly the same quality of jelly that they are accustomed to in their homes. Ask any good housekeeper what jelly powder she always insists on having

The Genesee Pure Food Company of Canada, Ltd.
Two Factories
LeRoy, N.Y. *Bridgeburg, Ont.*



How do you reduce Temperature in Broncho-Pneumonia?

HOLT says—"It must be remembered that the normal range of temperature in Broncho-Pneumonia is from 101° to 104.5° F. This temperature is not in itself exhausting, and the chances of recovery are not, I think, improved by systematic efforts at reducing it so long as it remains within these limits.

"Too much cannot be said in *condemnation* of the practice of *giving drugs* . . . . . for reduction of temperature."

Antiphlogistine hastens the elimination of toxins

thus favoring a decline in temperature.

Applied hot and thick over the entire thorax, Antiphlogistine, in a mild, yet effective manner, bleeds the patient into his own superficial capillaries; the pain lessened, *temperature declines*, deep-seated congestion and dyspnoea are relieved, while the heart, having a smaller volume of blood to deal with, conserves its strength.

Over 100,000 Physicians have used the genuine Antiphlogistine for 30 years. It is a *scientific*, not empirical, preparation.

Let us send you our booklet "The Pneumonic Lung"—it is replete with very valuable information and is *FREE*.

The Denver Chemical Mfg. Company
New York, U. S. A.
Laboratories: London, Sydney, Berlin, Paris, Buenos Aires, Barcelona, Montreal, Mexico City

Antiphlogistine
TRADE MARK



"Promotes Osmosis"

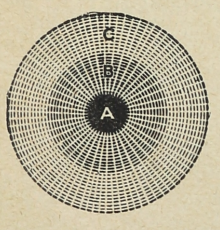
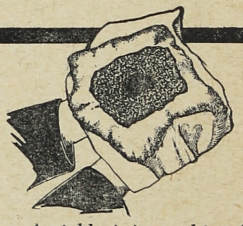
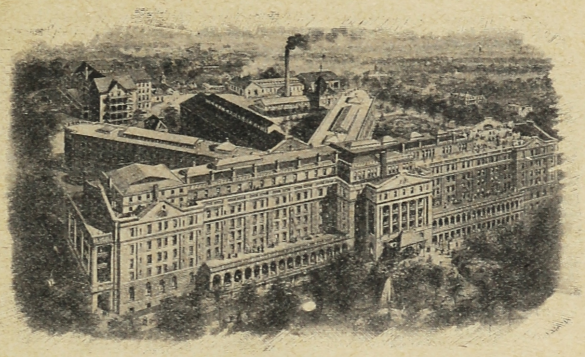


Diagram represents inflamed area. In zone "C" blood is flowing freely through underlying vessels. This forms a current away from the Antiphlogistine, whose liquid contents, therefore, follow the line of least resistance and enter the circulation through the physical process of endosmosis. In zone "A" there is stasis, no current tending to overcome Antiphlogistine's hygroscopic property. The line of least resistance for the liquid exudate is therefore, in the direction of the Antiphlogistine. In obedience to the same law exosmosis is going on in this zone, and the excess of moisture is thus accounted for.



Antiphlogistine poultice after application. Center moist. Periphery virtually dry.



An Invitation To Physicians

Physicians in good standing are cordially invited to visit the Battle Creek Sanitarium and Hospital at any time for observation and study, or for rest and treatment.

Special clinics for visiting physicians are conducted in connection with the Hospital, Dispensary and various laboratories.

Physicians in good standing are always welcome as guests, and accommodations for those who desire to make a prolonged stay are furnished at a moderate rate. No charge is made to physicians for regular medical examination or treatment. Special rates for treatment and medical attention are also granted dependent members of the physician's family.

An illustrated booklet telling of the Origin, Purposes and Methods of the institution, a copy of the current *Medical Bulletin*, and announcements of clinics, will be sent free upon request.

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Battle Creek **Room 271** **Michigan**

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MEDICATION: *Intravenous* or *intramuscular Injections.*

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MEDIUM DOSES: 30 to 35 centigr. every 6 or 8 days. *(8 to 10 injections for a course).*

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Rochester, N. Y.

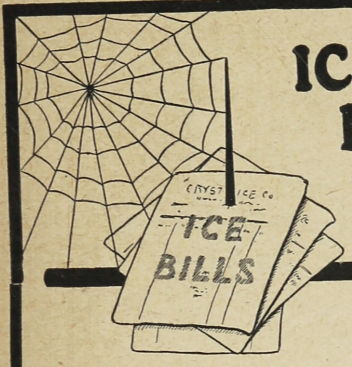
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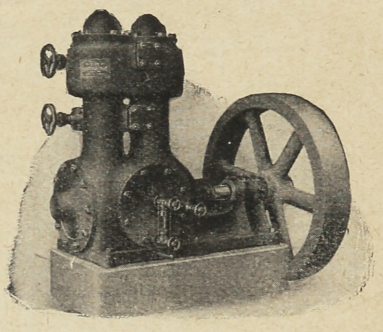


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